major setback as a result of the Bolaños crisis when Taiwan, which provided the country with nearly $200 million in aid between 1997 and 2003, announced it would cease sending aid until the national crisis is resolved.

LIGHT AT THE END OF THE TUNNEL

The PLC and Sandinista plan to oust the president, or at least strip him of much of his power, has largely ignored the sentiments of the average Nicaraguan. As Rodolfo Delgado Romero of the Managuabased Nicaraguan Studies Institute told COHA, ''Nicaragua must overcome the vicious cycle of crises and have the capacity to learn from errors that date back to the 19th century'' so it is no longer a country ''where the majority of the population is excluded from the decision-making process . . . a nation controlled by relatively exclusive elites for most of its history.'' Nicaragua is in desperate need for politicians who work on behalf of and truthfully represent its citizens.

The power struggle currently being witnessed in Nicaragua also demonstrates that the region is still plagued by corruption and political pandering. Such behavior invariably leads to unstable rule, which carries the potential for serious conflict and underscores the need for a corruption-free OAS that can act decisively as an arbiter to uphold democracy in the hemisphere. It is disconcerting to note that despite his three years of painfully-achieved economic progress in a nation wrestling with stifling underdevelopment, Bolaños is on the verge of falling victim to manipulations by self-serving political opponents. While it appears likely that President Bolaños will narrowly survive to finish his term, the events of the last two month have cast an almost impenetrable shadow over Nicaragua's troubled democracy.

HONORING JUDGE MICHAEL BATCHIK

HON. THADDEUS G. McCOTTER

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Mr. McCOTTER. Mr. Speaker, I rise today to acknowledge and honor Judge Michael Batchik upon his retirement after 25 years of service to the citizens of the 52nd District Court, 1st Division and the 52nd District Court, 2nd Division of Oakland County, Michigan.

Professionally, Judge Batchik served as chairman of the Judicial Conference Committee of the State Bar of Michigan, and has been an active member of numerous judicial organizations, including the Representative Assembly and the American Judges' Association. Mike has served as president of the Michigan District Judges' Association and president of the Oakland County District Judges' Association. He is also a past president of the Walled Lake Rotary.

During his tenure in the 52nd District Court, Judge Batchik initiated and implemented a highly successful jail alternative program. The program involves sentencing non-violent offenders to work in a structured community service program in lieu of jail, including a garden program that produces food for charitable organizations in the district. He has also been actively involved in implementing the very positive and successful ''Sobriety Court'' program at the Court. This program has been a key turning point in the lives of many drunk drivers, as well as reducing recidivism.

Mr. Speaker, I extend our entire community's sincere appreciation and gratitude to Judge Michael Batchik for his fine service to our community and our country; and wish him and his wife, Connie, the very best as they begin the next chapter of their lives.

REGARDING H. RES. 863

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Mr. FARR. Mr. Speaker, according to the Foreign Assistance Act, U.S. foreign assistance: ''shall be used in support of, rather than substitution for, the self-help efforts'' of developing countries and ''should focus on establishing and upgrading the institutional capacities of developing countries in order to promote long-term development.''

Over 40 years have passed since the enactment of the 1961 Foreign Assistance Act, and countries throughout, the world still face hurdles, including: extreme poverty, hunger, disease, high unemployment, and civil unrest. The U.S. Government only has a limited amount of resources available for international development assistance, and we need to ensure that we spend every dollar in the most efficient way possible to help as many people as possible. I strongly believe that the most efficient way to distribute foreign assistance is through building local capacity.

What exactly is local capacity building? Local capacity building can be defined as a continuous process where individuals, communities, organizations and governments improve their ability to understand and solve their development challenges in a sustainable way. Assistance means ''to give support'' . . . it doesn't mean do it yourself.

The most effective foreign assistance tools are not necessarily tangible things like bulldozers and construction equipment, or hiring American contractors to do the job in-country, but a more powerful and inanimate tool: knowledge. The transfer of knowledge via technical assistance, training and education is what will create long-term, sustainable development. This transfer of technical skills, be it teaching basic business skills for small businesses to flourish, demonstrating how to build wells, explaining the importance of rotating crops, developing a judicial system that hews to the rule of law, or promoting an educational system that provides opportunities for both men and women, is considered local capacity building and is fundamental for sustainable development.

Today, I am introducing a resolution that reaffirms the importance of local capacity building in U.S. foreign assistance programs. As my resolution illustrates, there is legal precedent and also considerable consensus within the development community that building local capacity is the key to creating long-term sustainable development.

But building local capacity isn't just done on an individual level, it needs to be done on a societal level and a governmental institutional level. Problems like poor access to health care, lack of financial literacy, teacher training are long-term, institutional problems. They are not going to be solved by a one-time infusion of foreign aid. Education and training of citizens in the developing world doesn't evaporate when the political climate or funding level changes in the United States or an international NGO reaches its strategic goals and departs.

The goal of local capacity building is to have individuals and governments take ownership of development programs and modify them to achieve lasting results. Where U.S. assistance can make a powerful difference is by providing the technical assistance and training to locals so that they are able to properly address their own problems. Communities can then take this knowledge and find ways to improve their own livelihoods on their own terms and in the appropriate cultural context.

An excellent example of foreign assistance technology transfer is USAID's Coffee Corps program. The U.S. sends renowned U.S. coffee specialists to coffee producing countries to assist coffee farmers in establishing the highest quality beans that will receive a higher market value. This knowledge transfer stays with individual producers and helps create more wealth and development within a rural community.

USAID has an excellent track record in promoting training programs for foreign aid recipients in key areas of economic development, and we need to recognize USAID's efforts and encourage other foreign assistance programs to push for a broadening of the usage of local capacity building within international development.

U.S. foreign assistance must invest heavily in programs that ''train the trainers'', promote educational and cultural exchanges, and fully fund grassroots development programs like the Peace Corps. The Millennium Challenge Corporation, MCC, appears to be making strides in promoting more sustainable development programs, but we must mandate that a country's commitment to building local capacity is a factor when the MCC considers a country's eligibility for funds.

I served as a Peace Corps volunteer in Colombia during the 1960s, and our mantra was: ''Work yourself out of a job.'' Peace Corps volunteers work to educate their counterparts in 'best practices' in areas such as agriculture, health, education, small business and IT development. These counterparts are then able to teach these new skills to other community members, enabling local residents to develop and sustain a better quality of life. ''Work yourself out of a job,'' shouldn't just be the mantra of Peace Corps volunteers. It should be reaffirmed as the central tenet of U.S. development assistance so that citizens in developing countries gain the knowledge to improve their lives and, in turn, improve the world.

SSGT RUSSELL SLAY

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Mr. GREEN of Texas. Mr. Speaker, I rise today to honor SSGT Russell Slay and to extend my deepest sympathies to his family and friends.

Staff Sergeant Slay was a constituent of the 29th District of Texas, and a true hero, who died on November 9, 2004 while serving his country in Operation Iraqi Freedom.

Russell Slay joined the U.S. Marine Corps at the age of 18, and had served his country

for 10 years. Staff Sergeant Slay was assigned to the 2d Amphibious Assault Vehicle Battalion, 3d Battalion, 1st Marine Regiment, Regimental Combat Team 1, 1st Marine Division, Camp Pendleton, CA. Staff Sergeant Slay was killed in the line of duty during Operation Iraqi Freedom while conducting combat operations in the Al Anbar Province.

Russell Slay leaves behind his father Roy Slay, his mother Donna Slay, and his step mother Peggy Slay, along with his two children Morgan, 9, and Walker, 5, who live in Humble.

I know his parents, family and friends are devastated by this loss, but they should be proud of the great man Russell Slay had become and that he died a hero while serving his country. America does not forget those who make the ultimate sacrifice.

His loss will be felt by all of Houston, and I ask that you remember the Slay family in your thoughts and prayers.

CELEBRATING NATIONAL HOMECARE AND HOSPICE MONTH

HON. DEBORAH PRYCE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Ms. PRYCE of Ohio. Mr. Speaker, I rise today to recognize the tremendous value homecare and hospice represents for American families. Homecare provides a family-friendly, clinically proven way of receiving quality healthcare for millions of Americans where they prefer to receive care—at home. November, National Homecare and Hospice Month, is an opportunity to recognize the importance of home care as an essential component of healthcare in my home state of Ohio and throughout the United States.

This important segment of the health care continuum allows patients with medical needs to remain in their homes, including those who are recovering, disabled, chronically or terminally ill who need medical, nursing, social, or therapeutic treatment. Homecare and hospice care represent a family value and a value for families. It's about quality health care and quality of life for millions of households across the United States.

Recent studies of homecare services show that homecare for selected conditions can shorten inpatient hospital stays, reduce the overall cost of care without compromising outcomes, and can improve patient and caregiver satisfaction.

As the American population ages, homecare is expected to grow in the years ahead. Fortunately, advances in technology allow virtually every service short of surgery to be delivered at home. This is good news for our nation's seniors and their families. And it's good news for younger generations who will benefit from continued advancements in technology to further improve the quality and accessibility of homecare.

Homecare and hospice care is an especially important option for people facing terminal illness. These individuals and their families are faced with enormous challenges in dealing with the fear that goes along with such a frightening diagnosis. Hospice treats the person, not the disease. It allows terminally ill patients and their families to experience the end of life together in the comfort and security of their homes or a home-like setting.

While homecare and hospice care serve a critical purpose for our nation's elderly population, these services also provide much-needed care for children with lifethreatening conditions and their families. Today in the United States, about one million children are living with life-threatening conditions and a staggering 55,000 children die each year. In an effort to make improvements to our system that treats terminally ill children, I introduced H.R. 3127, the Compassionate Care for Children Act, in the 108th Congress. This bill will help insure children with life-threatening illnesses have access to the treatments and care that they need and deserve, including hospice, palliative and curative care.

In honor of patients, their families, and caregivers in Ohio and throughout the United States, I join my colleagues in celebrating National Homecare and Hospice Month.

IMPROVING VETERANS EYE CARE

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Mr. BURGESS. Mr. Speaker, as health care consumers we all expect the highest quality of care available when we visit a health care facility. However, a recent decision by the Department of Veteran Affairs subjects our Nation's veterans to a lower standard of care that 49 out of 50 states permit. This directive, which permits optometrists to perform laser eye surgery in VA health facilities, only confuses the public and veterans about the difference between ophthalmologists and optometrists. In a recent survey of veterans who use the VA health system, 30 percent mistakenly thought optometrists were medical doctors. Further, over 95 percent of veterans think it is important to have a licensed medical doctors specializing in eye care performing their eye surgery in the VA. Our nation's veterans deserve better.

I submit the following for the RECORD:

Optometrists attend four-year Schools of Optometry but have no required post-graduate training or national board certification process. Beyond state optometric licensure, there is no ongoing, national re-certification process to assure the public of the competency of optometrists who are already in practice. In contrast, ophthalmologists are medical doctors who attend four years of medical school. They then complete one post-graduate year of general medical or surgical internship, three years of an ophthalmology residency training program, a national Board certification examination, and mandatory re-certification testing.

EDUCATION

Optometry School (4 years in length): Curriculum includes contact lenses, optics, vision sciences, sensory processing, vision therapy, practice management etc., and courses related to basic medical sciences and eye diseases. Average hours of course work based on a comparison of SUNY Optometry School are 597.3 hours. Optometrists have an average of 335.5 hours of lab and instruction on ocular disease and management.

Medical School (4 years in length): Curriculum focuses on fundamental principles of medicine and its underlying scientific concepts, including required courses on anatomy, biochemistry, genetics, physiology, microbiology and immunology, pathology, pharmacology and therapeutics and preventive medicine, including laboratory. Clinical sciences encompass all organ systems, including the important aspects of preventive, acute, chronic, continuing, rehabilitative and end-of-life care. Clinical experience includes family and internal medicine, obstetrics, gynecology, pediatrics, psychiatry and surgery. Average hours of coursework based on average across medical schools are 1, 436.10. In addition, ophthalmologists spend a minimum of 626 hours (not including medical school) of lab and instruction on ocular disease and management.

MANDATORY POST-GRADUATE TRAINING

Optometry: There is no mandatory post-graduate training. About 15% go on to an optional 1yr training program.

Ophthalmology (Additional 4 years in training): To become an ophthalmologist after medical school, one must complete 1 year of general medical or surgical internship, and 3 years of an ophthalmology residency training program. About 40% go on to a 1 or 2 year fellowship program to concentrate training and experience in a particular subspecialty. The Accreditation Council in Graduate Medical Education has standards in place for patient care responsibilities, minimum outpatient visits and minimum surgical numbers for residency programs.

CLINICAL EXPERIENCE DURING MANDATORY EDUCATION AND TRAINING

Optometry: A 1995–1996 survey of optometric curriculum found a range of 1,215 to 2,240 hours, with an average of 1,910 hours, for clinical experience across schools (a more recent study was not able to be located). During training, optometrists have no minimum requirements for the number of patient visits with ocular diseases or ocular surgical operative experience. There is also no requirement for systemic disease consultation.

Ophthalmology: Based on an estimate of an average of 60 hours per week (including on-call duty the maximum duty hours for residents is 80 hours per week) x 48 weeks x 5 years, at least 17,280 hours are for clinical experience throughout medical school internship and residency for ophthalmologists. During training, the ACGME requires that ophthalmologists have a minimum of 3,000 outpatient visits with a broad range of disease presentation and they must perform and assist at sufficient surgery to be skilled. There are also requirements for systemic disease consultation.

PROFESSIONAL REGULATION

Optometry: There is no national ''Board certification'' process in place for optometry. Beyond state licensure, there is no ongoing ''Board certification'' process to assure the public of the competency of optometrists who are already in practice.

Ophthalmology: There is a Board certification process to assure the public of successful completion of an accredited course of education and examination process by certified ophthalmologists. In addition to state licensure, an ongoing process, Maintenance of Certification, requires renewal of certification every 10 years for ophthalmologists certified in 1992 or later, and many other ophthalmologists voluntarily enter this process.

This data has been collected from SUNY State College of Optometry, Liaison Committee on Medical Education Accreditation Standards, U.S. Department of Education and ACGME.